std/aids control annual report 2000

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STD/AIDS Control

The British Columbia Centre for Disease Control is a provincial organization dedicated to the prevention and control of communicable diseases in B.C.

The Division of STD/AIDS Control is exclusively focused on the prevention and control of sexually-transmitted diseases (STDs), including HIV/AIDS.

Located in Vancouver, our activities fall into four main areas:

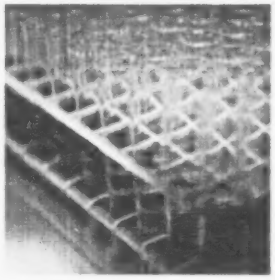
- we coordinate province-wide efforts to reduce the spread and minimize the adverse effects of STDs. We do this through education and awareness programs. The division works with clients both directly, through clinics and outreach workers, and indirectly through local and regional healthcare providers. The health, dignity and rights of our clients are our foremost concern.
- we provide STD/AIDS-related education and training resources for health care workers throughout the province, including medical residents, interns, public health nurses and other health care providers. We participate in conferences and frequently present on STD-related subjects, both in B.C. and in other jurisdictions.
- we provide epidemiologic data analysis and consulting services, acting as the provincial reporting centre for cases of STDs and AIDS. Provincial law requires most STDs be reported, so that trends and patterns can be accurately measured. Our role is to record, track and share this important data for the benefit of provincial health care authorities, as well as authorities in other jurisdictions including international organizations and governments.
- we participate in STD/AIDS related research and teaching as a university affiliated organization which helps us remain current in our approach.

This annual report describes some of the objectives, activities and achievements that marked the past year at STD/AIDS Control. It also includes detailed epidemiology statistics. More information on many of the subjects discussed here can be found on our website at www.bccdc.org, or through our resource centre at 604-660-2090.

highlights of 2000

In the year 2000, STD/AIDS Control

- Conducted a mass treatment campaign to arrest an outbreak of infectious syphilis in Vancouver's Downtown Eastside (DTES). It was a bold initiative – such campaigns are seldom attempted in North America – and yielded multiple benefits. In addition to administering treatment to nearly 6000 people and reducing the spread of the disease, the division gained valuable insights into STD mass treatment for marginalized populations. Our experiences in this initiative have been the subject of several journal articles and conference presentations.



- Participated in the research, development and introduction of a new method for testing for HIV, known as HIV point of care, or the rapid test, which is faster and more efficient than the current standard. The rapid test enables HIV testing to be done at any health care facility and provides a result in 15 to 20 minutes. This compares to the standard test which requires laboratory testing and takes up to two weeks to yield final results. Because of our extensive early-stage involvement with the rapid test, we have gained considerable experience with the process and are frequently consulted on its implementation by health care authorities.

- Adopted a new computer software program to provide timely and relevant epidemiology data to Medical Health Officers throughout the province. The software, called Impromptu, enables MHOs anywhere in the province to access regional reports in the central STD/ AIDS database directly from their offices. MHOs benefit from easier and quicker access to more relevant data, and we're able to make a valuable contribution to effective STD/AIDS control throughout the province.

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director's letter

Dr. Michael Rekart, Director

A Message from the Director

Once again in 2000, all the staff at STD/AIDS Control can take pride in a very successful year. We delivered high quality and compassionate care and support to tens of thousands of patients. We provided up-to-date education and training opportunities to many health care workers. We gave accurate and useful advice to governments, groups and individuals. We collected and analyzed STD, HIV and AIDS data with absolute confidentiality. We performed cutting-edge research. We worked effectively and respectfully with our various partners. We improved the lives of poor men, women and children in Vietnam. And we took care of each other.

This annual report will provide details and descriptions of several of these activities. Delivering 6000 treatment doses of azithromycin in an attempt to curtail the ongoing outbreak of syphilis in BC was a vivid demonstration of our ability to assess a problem, to develop an innovative control strategy, to build a wide base of support and to successfully deliver a complex initiative. The extra time and effort that our staff willingly devoted to the development and implementation of programs for sex workers and drug users in Ho Chi Minh City illustrates our commitment to people in need wherever they may live. Our important role in Canada with respect to the development of public health information systems and the evaluation of a faster and easier HIV test demonstrates our ability to lead.

I am exceedingly proud of our continuing work with two of Canada's most disadvantaged populations – Vancouver's Downtown Eastside and BC's Aboriginal people. Through the Street Nurse and the BC Aboriginal AIDS Awareness Programs, our staff took on the difficult challenge of increasing knowledge, changing behavior and promoting health in communities where poverty and discrimination are more immediate concerns.

I cannot report that any STDs were eliminated in 2000, but we're working on that too.

Michael L. Rekart

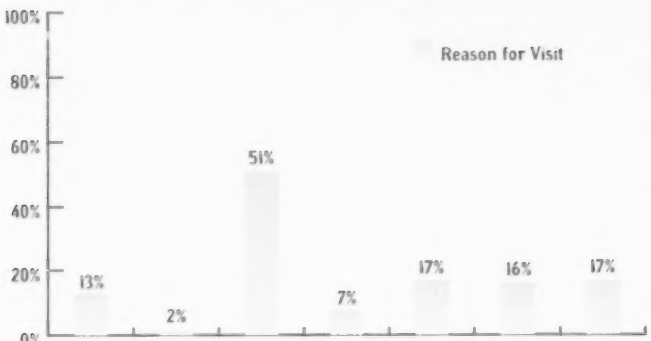
Dr. Michael Rekart
Director, STD/AIDS Control

divisional activities

STD Clinic and Street Nurses

The division's services are delivered through two principal channels: the STD Control Clinic, located in the BCCDC building at 655 West 12 Avenue in Vancouver, and the Street Nurse Program, which operates from a number of locations throughout the city.

1.1 Primary Reason For Visit



	Hepatitis	Contact to STD	HIV Testing	Wart Treatment	STD Screening	STD Symptoms	Other*
Number of Visits	2603	473	9879	1298	3379	3060	3399

* *Other includes: Azithromycin pilot, birth control, counselling, consultation, follow-up, immigration, pregnancy test, results, TB skin testing, treatment, test of cure.*

** *Percentage does not equal 100% because one client may have several reasons for visit (e.g. HIV testing, symptoms and STD screening).*

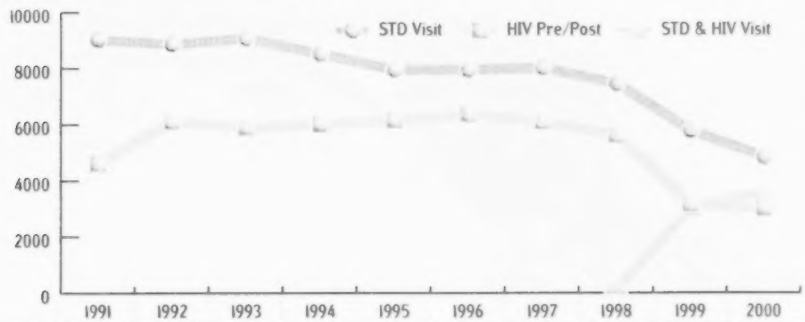
During 2000 the STD Control Clinic and Street Nurse Program reported 19643 clinic visits. In 9,879 or 51% of all clinic visits HIV testing was given as a reason for the visit. This includes some aspect of HIV testing such as pre-test or post-test counselling or follow-up for an HIV test. Thirty-three percent (6,439) of visits were because of concern about an STD, with 16% presenting with STD symptoms and 17% requesting screening for an STD. Genital wart treatment was the reason for 1298 or 7% of visits and 13% or 2603 returning for hepatitis A or B vaccines. Almost 500 or 2% of visits were the result of contact to a known STD.

West 12th Clinic

The STD Clinic on 12th Avenue is centrally located, easily accessible to clients, close to the downtown core and adjacent to Vancouver General Hospital. As the site of our primary clinical facility, it provides STD assessment and management services, including HIV testing, for clients from throughout the Lower Mainland. In addition, it is the centre of our epidemiology, education, research and administration activities. At this location we:

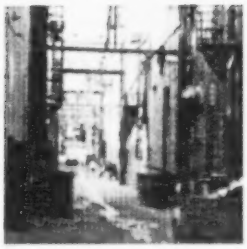
- conduct STD surveillance, reporting, data management and related epidemiology services
- conduct and co-ordinate ongoing STD/AIDS research at our own and affiliated facilities
- provide training in STD clinical management for health care workers from across the province
- operate the province-wide STD/AIDS information phone line
- maintain an STD/AIDS education resource centre for province-wide use
- provide overall administration of all division operations

1.2 West 12th Clinic Visits



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
STD Visit	9,032	8,870	9,085	8,525	7,959	7,962	8,040	7,468	5,792	4,874
HIV Pre/Post	4,619	6,113	5,891	6,018	6,154	6,368	6,108	5,617	3,165	3,012
STD & HIV Visit	–	–	–	–	–	–	–	309	3,093	3,591
Total Visits	13,651	14,983	14,976	14,543	14,113	14,330	14,148	13,394	12,050	11,477

1998 was the first year a visit for both an STD and HIV were counted separately. The decline in STD and HIV Pre/Post visits may be attributed to this revised recording method.



Street Nurse Program (STD/AIDS Outreach)

The Street Nurse Program is the outreach component of STD/AIDS Control. The focus of this unique nursing-based program is to offer STD/AIDS diagnosis, treatment and prevention services to marginalized at-risk populations, including drug users, sex trade workers, street-involved youth and adults, refugees, the homeless, and gay, lesbian and transgendered persons.

The program operates in a number of formats. There are two dedicated clinics, Main Street and Bute, and a number of small clinic sites situated within other community service organizations. Street outreach – services delivered by mobile teams on foot or from a van – take the practice outside the walls of clinic settings. The street nurse team includes twelve full-time nurses, two part-time nurses and two health care workers.

The street nurses' services are provided within a framework of prevention, harm reduction and health promotion. By delivering services to clients in their own, familiar communities and by treating all clients with respect, understanding and acceptance, the street nurses achieve a high level of success. A willingness to develop flexible strategies to access hard-to-reach groups and constant re-assessment of the program's overall effectiveness also contribute to the continuing success of the Street Nurse program.

Education is an integral component of the program. STD/HIV education and harm reduction practices are taught to individuals, client groups, other health care providers, community agencies, nursing schools, corrections staff and inmates, group homes and the like, in both formal and informal settings. In addition, this close interaction with other health facilities, drug and alcohol programs and community agencies helps the street nurses assist clients to access appropriate services for their individual needs.

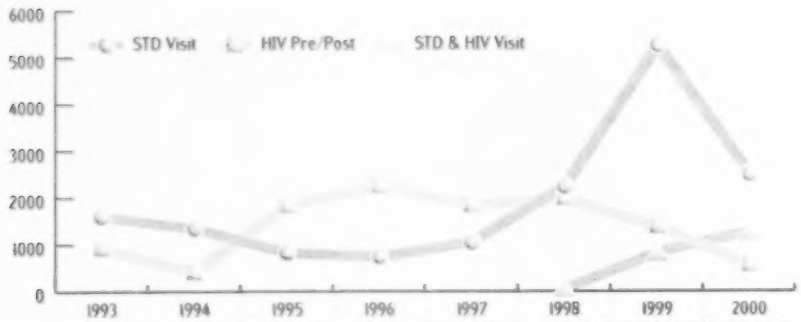
Main Street Clinic

The Main Street Clinic is located in the Downtown Eastside of Vancouver, a community challenged by a disproportionately high prevalence of addiction and substance abuse, mental health problems, sex trade involvement, physical and sexual abuse, homelessness, poverty and chronic health conditions such as HIV, tuberculosis and hepatitis C.

The clinic is located above the main Vancouver needle exchange, across the street from the provincial courthouse. It is accessed by a broad range of marginalized people who are at high risk for STDs, HIV and hepatitis C. Clinic staff provide STD and HIV counselling, education, testing, treatment and follow-up.* Needle exchange and education in harm reduction practices are integral to all health services offered. Working closely with other agencies, clinic staff also provide clients with referrals to services for health and social needs.

**This is provided in the context of drug use related complications, which are also treated if urgent.*

1.3 Main Street Clinic Visits



	1993	1994	1995	1996	1997	1998	1999	2000
STD Visit	1,606	1,353	831	751	1,056	2,243	5,259	2,513
HIV Pre/Post	934	412	1,843	2,259	1,855	1,983	1,391	575
STD & HIV Visit	–	–	–	–	–	81	845	1,292
Outreach Encounter	5,881	8,822	11,342	13,004	15,971	21,359	22,918	27,700
Total Visits	8,421	10,587	14,016	16,014	18,882	25,666	22,918	32,080

1998 was the first year STD and HIV visits were counted separately.

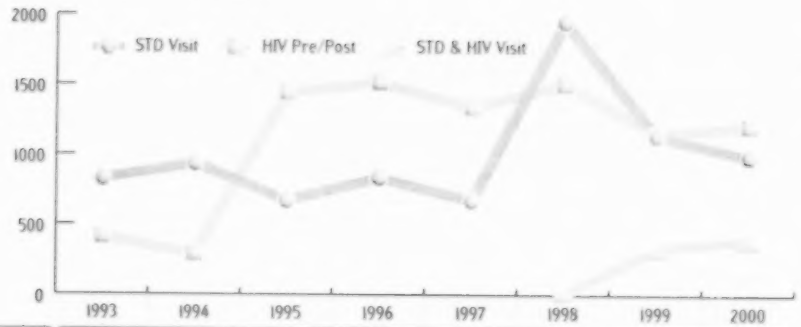
Note: An outreach "encounter" includes all services to clients for STD/HIV, vaccines, wound care, education and referrals.

Bute Clinic

The Bute Clinic is situated in the Lesbian Gay Bisexual Transgendered (LGBT) Community Centre in Vancouver's West End. It serves a primarily gay and bisexual population, though there has been an apparent increase in the number of street involved youth and injection drug users accessing the clinic.

The Bute Clinic provides STD/HIV counselling, testing, treatment and follow-up services, along with harm reduction education and needle exchange. The clinic is also the basis for outreach work to bathhouses, gay bars and clubs in the area.

1.4 Bute Clinic Visits



	1993	1994	1995	1996	1997	1998	1999	2000
STD Visit	825	936	673	835	673	1,946	1,137	988
HIV Pre/Post	415	290	1,441	1,514	1,336	1,503	1,150	1,209
STD & HIV Visit	–	–	–	–	–	22	334	396
Outreach Encounter	2,663	3,744	4,026	3,825	4,193	5,848	5,332	6,187
Total Visits	3,909	4,970	6,140	6,174	6,202	9,319	6,953	8,780

1998 was the first year STD and HIV visits were counted separately.

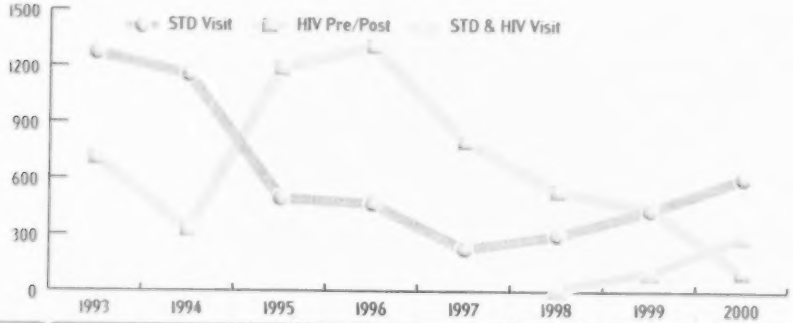
Note: One possible explanation for the 1998 increase in STD visit numbers is the Hepatitis A vaccine campaign.

Satellite and Mobile Services

The street nurses offer services through several satellite clinics that operate within space provided in other community agencies where people access social services. Our presence in these locations increases our accessibility, especially among the most marginalized and difficult to reach at-risk populations. Using a harm reduction and health promotion framework, the nurses provide STD and HIV prevention education, counselling, testing, treatment, follow up, vaccinations, and referral to agencies for housing, detox, primary care and other social and health services.

Street nurses work with clients on the streets of the DTES and other areas of the Lower Mainland. Travelling either on foot or by van, they are able to make direct contact with sex trade workers, people living in single room occupancies, the homeless, street youth and others. The mobile clinics also facilitate enhanced contact tracing and partner notification.

1.5 Satellite and Mobile Services Clinic Visits

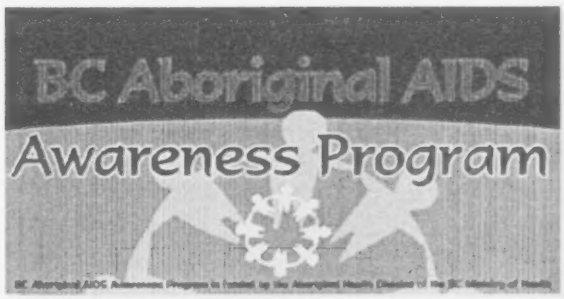


	1993	1994	1995	1996	1997	1998	1999	2000
STD Visit	1,272	1,155	495	467	226	300	435	607
HIV Pre/Post	709	327	1,191	1,307	797	534	440	105
STD & HIV Visit	-	-	-	-	-	15	109	301
Outreach Encounter	11,009	13,652	16,410	22,600	20,816	24,404	26,542	25,699
Total Visits	12,990	115,134	18,096	23,653	21,839	25,253	27,526	26,712

Satellite Clinics include: Cordova Detox, Vancouver Detox, BC Correctional Centre for Women, agencies in the DTES (Youth Action Coalition, DTES Women's Centre, Urban Native Youth, First United Church, WISH, Powell Place, Crabtree Corner), agencies in the Downtown South (Covenant House, Street Youth Services, La Boussele, Bath Houses), Broadway Youth Resource Centre and mobile van service.

*1998 was the first year STD and HIV visits were counted separately.

The BC Aboriginal AIDS Awareness Program



The BC Aboriginal AIDS Awareness Program (BCAAAP) was developed by STD/AIDS Control in 1989 to address the rising rates of AIDS in BC's Aboriginal communities. The program was designed to recognize that, while BC's Aboriginal populations constituted a high-risk group, they also possessed distinct cultural and social characteristics that merited specifically tailored prevention and health promotion initiatives.

Subsequently, BCAAAP has developed a series of measures and programs to provide STD, AIDS and hepatitis education to Aboriginal communities and organizations throughout the province, including training for health care and human services workers. The programs are designed to be culturally appropriate, community-based and readily available at the local level. They focus on spiritual, mental and emotional health as well as physical well-being. We also provide referrals, consultation and assistance with developing appropriate information materials. The program presently employs two full time workers, a Program Manager and an Educator, both of First Nations descent.

BCAAAP's unique approach to serving its client group is well illustrated in the "Door to Door" project which was carried out last year. The project targeted four northern communities where no formal HIV/AIDS awareness programs had been implemented. It employed a local tradition for gathering the community together whereby people go literally "door to door", personally inviting everyone to attend the event. The event, in this case, was a workshop on STD/AIDS and hepatitis awareness.

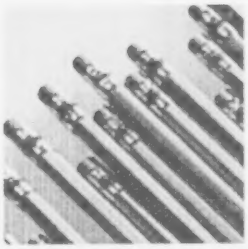
Our team, which also included representatives from the BC Women's Hospital and the Aboriginal organization Healing Our Spirit, went door to door in each community to extend a personal invitation to attend the workshops. The project was a great success. The gatherings included a cultural celebration and an evening feast, making the events more relevant and memorable than a straightforward workshop.

BCAAAP also works to reach Aboriginals living in urban areas. In Vancouver, for example, an Elder was contracted to help provide culturally-appropriate activities and programs at a downtown AIDS clinic. Since the Elder's arrival, Aboriginals in the community have become more willing to participate in activities and programs at the clinic.

Some of BCAAAP's additional accomplishments include:

- completed a female condom project and awareness campaign
- provided 98 STD/AIDS and hepatitis awareness workshops
- provided four "Train the Trainer" workshops
- made presentations at five conferences
- involved in nineteen health fairs at Aboriginal gatherings

In total, BCAAAP reached over 10,000 people in the past year: the demand for our services continues to grow.



Education and Communications

Education: reaching, teaching

The division's educational initiatives are broad, and the aims of our educational activities are two-fold. Firstly, we aim to educate our clients, the people of British Columbia, on how to prevent the spread of STDs, including HIV/AIDS. Secondly, we work to share our knowledge of disease control with fellow health care professionals at local, regional, national and international levels.

Education efforts are an ongoing aspect of virtually all of our client-centred clinical and outreach activities. We endeavour to ensure that all the clients we contact are given information on STD/HIV prevention and risk reduction. We also work with local health groups and educators to provide resources to help them with their own community-based educational efforts.

We offer a variety of training programs to health care professionals throughout the province. These programs address various topics related to effective STD/AIDS prevention and control. Many are offered on an ongoing, scheduled basis; others are structured to enable distance learning for remote and rural communities.

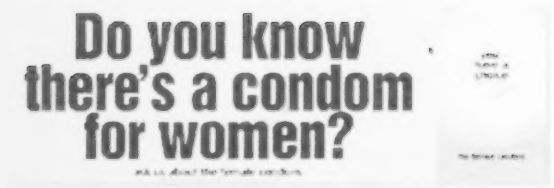
In addition, we provide a wide range of our education and information services to the health care community, helping practitioners throughout BC deliver current and effective STD and AIDS prevention and treatment for patients.

We also design specific programs to address new challenges. One example is "In the Hands of Women", our project to assess whether the female condom is a viable barrier prevention option for women. Our demonstration project began in early 1999 with a two site pilot; a year later, four more sites were added. Participants were recruited through STD clinics and AIDS organizations, contact with nurses, and via newspaper ads and posters. We focused on sexually active heterosexual women,

from a wide array of ethnic groups, who were determined to be at risk for STDs. The participants were asked to use the female condom for a period of time, providing nurses with feedback. The female condom was seen by participants as an effective aid to help prevent STDs and pregnancies, while maintaining sexual health.

Internationally, our engagement in a project in Ho Chi Minh City (formerly Saigon) in Vietnam continues to expand. Using our STD/AIDS Control program in B.C. as a model, we are working with the local government and Vietnamese health care workers to increase their capacity to provide high quality STD prevention and treatment services to sex trade workers and injection drug users. Currently, we are learning things that will be of value to our work here at home. It's a project that eloquently illustrates both the global nature of disease control, and the value of exchanging experience and expertise with colleagues.

The division also administers an annual STD/AIDS communications budget that funds local awareness and education projects. These programs are developed and delivered by community-based health care boards and societies to target local issues. In the 2000-2001 period, over a dozen projects were funded in communities throughout the province. *(see next page)*



At the resource centre, we maintain an extensive library of STD/AIDS-related education materials which are freely loaned to health care professionals and educators in the province.

The knowledge and expertise of our staff is recognized throughout the medical community, and the division has earned a reputation as an authority in the field. Members of our division are frequently in demand to provide expertise, training and consultation to other health care jurisdictions. Our members make important contributions to medical journals and present at key conferences.

List of Projects Funded in 2000-2001

Organization	Description
North West Community Health Services Society, Terrace.	Employ a sexual health educator for one week to deliver sexual health information to elementary, middle and high schools and host a theater sports event on World AIDS Day promoting sexual health messages.
Northern Interior Regional Health, Prince George.	Provide a peer education program for post secondary students that will raise awareness about STDs, risk behaviour and sexual decision making.
Simon Fraser Health Region, Coquitlam.	Building on last year's project that identified demographics, health needs and location of people with high risk behaviors, a training consultant will assist in developing a peer education program for at risk groups in each community.
Peace Liard Health Services Society, Dawson Creek.	Develop and implement a chlamydia awareness campaign.
East Kootenay Community Health Services Society, Cranbrook.	Create a touring live theater production and art show through interactive, multi-media and live performances based on relevant STD/HIV/AIDS information.
North Okanagan Health Region, Vernon.	Provide HIV/STD prevention education to operators and staff in group homes for the mentally challenged.
Fraser Valley Health Region, Chilliwack.	Recruit and train seven youth to provide peer education/leadership regarding STD/HIV and sexual health issues.

Organization	Description
Richmond Health Services, Richmond.	Complete two needs assessments for HIV+ women in Richmond. One, identifying the needs with respect to education, advocacy, support, community services, health care and other services and the second, identifying community services/resources in Richmond for HIV+ women.
South Fraser Health Region, Surrey.	Recruit a group of local IDUs to train as peer educators in harm reduction strategies. In return, they will provide education sessions to their peers and provide feedback on IDU risk behaviors.
Coast Garibaldi Community Health Services Society, Powell River.	Produce a portable "Women & HIV/AIDS" teaching resource kit with current information on prevention, testing and treatment for HIV/AIDS. Provide training sessions on use of the kit and market and distribute the kit to organizations serving women.
Central Vancouver Island Health Region, Parksville.	Produce a document for the BC CAPP curriculum that addresses healthy sexuality and healthy sexual choices for youth.
Central Vancouver Island Health Region, Port Alberni.	Organize a BC CAPP committee to develop a plan and resources; promote and support a peer education model; and improve HIV/STD prevention and the availability of testing.
Capital Health Region, Victoria.	Distribute RARE project to participants and a wider audience through written and promotional materials and discussion groups. Develop framework for ongoing community feedback process.
Upper Island Central Coast Community Health Services, Campbell River.	Produce an inventory of STD/HIV and sexual health resources available in the region, document and locate resource needs and purchase resources.

Presentations, Publications and Research

An important part of the division's mandate is to share our knowledge and expertise with our colleagues throughout the health care community, a community that is truly global. We are proud to say the staff at STD/AIDS Control are widely regarded as authorities in their field and we frequently share our expertise with fellow health care professionals through publications and presentations. In the year 2000, division staff made the following contributions:

STD/AIDS Control Staff Presentations

Rapid HIV Study Presentation, Canadian Association for HIV Research conference, Montreal, April 2000. Doreen MacLauchlan

Female Condom Presentation, Aboriginal Women and Wellness Conference, Vancouver, January 2000. Jacqueline Barnett, Mike Rekart and Lucy Barney

Preparing A Supportive Community, Healing Our Spirit's Annual Conference, Honoring Children and Families, Cranbrook, March 2000. Melanie Rivers

Aboriginal People and HIV/AIDS, BCCDC Grand Rounds, Vancouver, June 2000. Melanie Rivers and Lucy Barney.

Lecture on STDs, Lions Gate Hospital Grand Rounds, North Vancouver, Spring 2000. Dr. Hugh Jones

Lecture on STDs, Vancouver General Hospital, Obstetrics and Gynecology Grand Rounds, Vancouver, Fall 2000. Dr. Hugh Jones

Lecture on STDs, UBC Continuing Medical Education Update for GPs, Vancouver, Fall 2000. Dr. Hugh Jones

HIV Rapid Test: Legal and Clinical Issues Presentation, Toronto, 2000. Daphne Spencer

HIV Rapid Test, Biochem Pharmaceuticals, Vancouver, May 2000. Daphne Spencer

HIV Rapid Test, Biochem Pharmaceuticals, Calgary, May 2000. Daphne Spencer

STD Testing and Treatment in Ho Chi Minh City (Vietnam), World Congress of Medical Technologists, Vancouver, May 2000. Dr. M.L. Rekart

Syphilis, UBC Health Care and Epidemiology Rounds, Vancouver, September 2000. Dr. M.L. Rekart

Syphilis Mass Treatment, Meeting on Phase Specific Interventions in the Control of STDs, Rome, October 2000. Dr. M.L. Rekart

STD Control in Vietnam, Meeting on Phase Specific Interventions in the Control of STDs, Rome, October 2000. Dr. M.L. Rekart

Publications

Authors bolded are STD/AIDS Control staff.

Articles:

Rekart ML, Patrick DM, Jolly A, Wong T, Morshed M, **Jones HD, Montgomery C, Knowles L, Chakroborty B, Maginley J**. *Mass treatment/prophylaxis during an outbreak of infectious syphilis in Vancouver, B.C.* Canada Communicable Disease Report, June 15, 2000; 26(12): 101-105.

Abstracts:

Kim J, Calder-Kent B, Malloch L, Prodhomme I, Jamison K, Macpherson S, Fortier G, Dawood M, Chan E, Fonseca K, Prassad E, **Rekart ML**, Jochem K, Archibald C. *Preliminary Evaluation of the Avidity Index Protocol on the Genetic Systems rLAV and Biochem Detect HIV 1&2 EIA Kits to Distinguish Incident Versus Prevalent Infections.* Ninth Annual Canadian Conference on HIV/AIDS Research, Montreal, PQ, April 2000. Canadian Journal of Infectious Diseases 2000;11(Suppl B): Abstract 138P.

Patrick DM, **Spencer D**, **Rekart ML**, **Knowles L**, **Barnett J**, **MacDougall R**, **MacLauchlan D**, Cote YP. *How do patients and care providers view the experience of rapid, point of care, HIV testing?* Ninth Annual Canadian Conference on HIV/AIDS Research, Montreal, PQ, April 2000. Canadian Journal of Infectious Diseases 2000;11(Suppl B): Abstract 432.

Patrick DM, Dawar M, Krajden M, Cook D, Ng H, Lam ML, **Rekart ML**. *Herpes simplex seroprevalence type 2 seroprevalence in Canadian women.* International Congress on Antimicrobials and Chemotherapy 2000, Toronto, Abstract 1193.

Hoang LMN, **Rekart ML**. *Physical examination and diagnostic tests versus diagnostic algorithms may prevent over-diagnosis of sexually transmitted diseases (STDs) and excessive antibiotic use in female sex trade workers in Ho Chi Minh City.* 43rd Annual Meeting, Western Pharmacology Society, Tuscon, January 2000.

Rekart ML. *HIV Rapid Testing in an STD Clinic.* XIII International Conference on AIDS, Durban, South Africa, July 2000. Abstract 7176.

Conference Proceedings:

Patrick DM, **Rekart ML**, et al. *Syphilis Mass Treatment with an Oral Antimicrobial: Background, Epidemiology and Rationale.* Meeting on Phase-Specific Interventions in the Control of STDs. Rome, October 2000.

Rekart ML. *Sexually Transmitted Disease Control in Ho Chi Minh City, Vietnam.* Meeting on Phase-Specific Interventions in the Control of STDs. Rome, October 2000.

Rekart ML, Patrick DM, et al. *Syphilis Mass Treatment with an Oral Antimicrobial: Planning, Delivery and Results.* Meeting on Phase-Specific Interventions in the Control of STDs. Rome, October 2000.

Reports:

Rekart ML. *The Ho Chi Minh City STD/AIDS Clinic and Outreach Project: Report on the Training Phase.* July 2000.

highlights of 2000

Syphilis Mass Treatment Campaign

In early 2000, the division implemented a bold and unusual initiative to combat an exceptional public health challenge.

STD/AIDS Control detected an outbreak of infectious syphilis in the province in late 1997. Despite increasing our control and prevention efforts, infection rates continued to climb throughout the following year, reaching epidemic proportions. In 1999, we began to consider alternative strategies, specifically a mass treatment campaign.

Mass treatment is an STD control strategy that is rarely attempted in industrialized societies; it is more commonly associated with developing countries where medical services are not readily or widely available. However, the outbreak we were dealing with was concentrated in Vancouver's DTES, a community where many residents live in conditions of poverty, discrimination and poor access to health care, conditions reminiscent of a developing country. This was one of the first times a campaign of this kind had been undertaken in North America.

A mass treatment campaign involves identifying the population at risk from the disease, then administering treatment to as many members of the target group as possible within a short period of time. It is as much a logistical challenge as a medical one, especially given that our target group included marginalized populations who customarily avoid contact with public officials: sex trade workers and their clients, street youth, injection drug users, men who have anonymous sex with men.

This campaign would not have been feasible without the trust and respect that our organization, and in particular our street nurses, have earned from local residents. Street nurses have been active in the Downtown Eastside for a dozen years, building the foundation that enabled us to confidently undertake the mass treatment program. Street nurses were involved at all stages of the planning process to ensure that patients' special needs were considered.

Having determined that a mass treatment campaign was feasible and worthwhile, we began planning and preparation, a process that took roughly six months and involved thousands of hours of work by many people. Planning steps included:

- obtain support of the medical practitioners and the community at large for the initiative
- secure funding
- resolve legal and ethical issues
- raise awareness and obtain support from the target community
- conduct and evaluate a pilot study
- design and execute a media strategy
- get support and involvement of neighbouring health care jurisdictions
- develop and produce data collection forms and educational materials
- obtain and package the drug
- develop a distribution plan
- develop an evaluation strategy

After months of preparation, the treatment itself was delivered in early 2000. During two six-day "blitz" periods, one in January and a second four weeks later, almost 6000 doses were administered to persons at risk in the DTES and adjacent areas. With the medication (azithromycin dihydrate 1.8 grams in a single oral dose) participants were informed about the purpose of the campaign and given handouts with information on STD treatment and prevention.

The campaign also included "secondary carry", by which participants were permitted to take treatment doses to their partners or other contacts who were at risk, but were unlikely to participate directly in the program.

We began assessment following the first week of treatment, adjusting our delivery methods prior to the second round. A final evaluation followed.

We were satisfied that the treatment had successfully been delivered to a significant number of people in the intended target group.

Subsequent surveillance indicated that syphilis rates declined for several months following the campaign, suggesting that our efforts to reduce the outbreak were successful. (Note: the rates have since begun to climb again) We did not achieve our primary objective of the campaign – to terminate the syphilis outbreak – but the early evidence indicates we have certainly had a measurable impact. We believe the campaign also had a secondary effect – a short term decrease in gonorrhea rates.

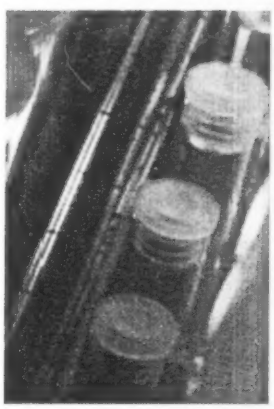
Apart from the direct benefits to public health, the mass treatment campaign helped to raise STD awareness in the DTES and throughout the Lower Mainland. We introduced our services to many at-risk populations who previously had little contact with STD/AIDS Control.

We, too, learned many lessons from the program. It proved the viability of mass treatment for difficult to access urban populations and offered insight into the value of "secondary carry" in reaching otherwise inaccessible groups.

Most importantly, perhaps, the mass treatment campaign reinforced the critical role that our street nurses play in maintaining the day to day health of our clients in this challenging environment.

For more information on the Syphilis Mass Treatment Campaign call the STD/AIDS Control Resource Centre at 604-660-2090.

HIV Rapid Test



The division participated in the research, development and introduction of a new method for testing for HIV, called the rapid test due to its quick results.

Historically, HIV testing has been a lengthy process, involving two separate visits by the client to a health care facility – once to give a blood sample and again to receive the results (HIV results are usually not given out by telephone) – separated by a waiting period of several days while the sample is sent to a provincial laboratory for testing. The entire process takes up to two weeks.

The rapid test can be administered directly by a health care provider in an examining room and provides a result in 15 to 20 minutes. It can provide a confirmed negative (non-reactive) result, or a preliminary positive (reactive) result. If a reactive result is obtained, it must be confirmed by having the blood sample tested by a provincial laboratory. The provincial laboratory, in turn, provides rapid turnaround for confirmatory testing of positive results.

Like the standard method, the rapid test requires that the client receive pre-test counselling and provide informed consent. Accurate interpretation of the rapid test still depends on a six month pre-test period of risk-free behaviour.

The rapid test represents a significant improvement in quality of service for the client, and in efficiency for the health care system. STD/AIDS Control was an early supporter of the rapid test, and we assisted with its development and implementation in several ways: we participated in clinical trials undertaken by Biochem, the manufacturer of the device, as part of the procedure to obtain regulatory approval; we also conducted our own research to study the effects of the new testing option on both clients and health care providers.

As a result of our extensive early stage involvement with the HIV rapid test, the division has developed an expertise regarding the process. We developed counselling guidelines for the use of the HIV rapid test, available for national distribution. Division staff are consulted by other local clinics who are considering adopting the technique and are frequently asked to participate in conferences and committees where the HIV rapid test implementation is discussed.

In B.C. we began offering the rapid test as an alternative HIV testing method to clients at our clinics where it is commonly chosen over the standard method.

For more information on the HIV rapid test call the STD/AIDS Control Resource Centre at 604-660-2090.

Impromptu – Intranet Web Reporting

Impromptu: Data on Demand

Epidemiology is a critical function of our organization, but knowledge is only valuable when it is accessible. Responding to requests from Medical Health Officers (MHOs) and other users for improved access to data, the BCCDC began using a software program called Impromptu.

Impromptu greatly improves our ability to provide relevant epidemiology data to MHOs throughout the province. Formerly, MHOs relied on reports published by our research officer. Custom reports could be requested, but this process could take several days.

Impromptu enables MHOs anywhere in the province to access data in the central STD database directly from their offices via a special program on our intranet. The program provides immediate access to most items in the division's STD database and enables users to request data pertinent to their needs. Using a simple log-in and web-based interface, MHOs can quickly and easily call up regional, age and gender-specific reports as needed, or they can schedule delivery of these reports on a regular basis. The reports contain no personal identifiers.

MHOs now have faster access to relevant data, which aids and speeds their decision making. The improved service and communication is helping forge a stronger relationship between our organization and our colleagues in the health care industry, which benefits us all.

The Impromptu database, which is maintained by STD/AIDS research personnel, currently contains data on chlamydia, gonorrhea and syphilis. AIDS and HIV data will be added in the future.

incidence trends

A brief summary of overall trends observed in BC during the year 2000:

- New case reports of chlamydia genital infection increased, continuing a trend which began in 1997. These recent increases have been reported across B.C. but females, especially 15-19 years of age, still account for significantly more cases than males. Perhaps the most important incident during the year was a dramatic increase in chlamydia diagnoses which occurred after a public education program in the Northern Interior Health Unit (NIHU). Taking into account the high likelihood of asymptomatic chlamydia infection, the province-wide incidence of disease and the NIHU campaign results, it is clear that there are many unreported infections. Efforts to find cases will need to be a priority in future years. Annual case reports will likely continue to rise slowly unless case finding improves dramatically.
- Gonorrhea decreased, after two successive years of moderate increases. Cases were concentrated in the Lower Mainland, especially Vancouver, and most were in males, in stark contrast to chlamydia. It is hoped that gonorrhea cases will continue to decrease.
- Syphilis rates also decreased in 2000, largely as a result of the syphilis mass treatment initiative, which affected cases for a period of six to seven months. Nonetheless, syphilis rates were much higher in B.C. than elsewhere in Canada and still constitute a serious outbreak. Syphilis was heavily concentrated in Vancouver's DTES and primarily associated with the sex trade.
- It is clear from the epidemiology of these three STDs that they affect different and distinct populations, which suggests that control and prevention measures that rely on generic messages are not likely to be effective.
- HIV and AIDS continued their declines of recent years in 2000, although there was an increase in newly-positive HIV tests in gay men and men of colour – Blacks, Asians and Hispanics. The same trend has been observed in several other North American locales and urgent action is required to prevent a new epidemic of HIV infection.
- Aboriginal women continued to be over-represented with 25% of newly positive HIV cases among females.

Detailed statistics may be found in the back section of this report.

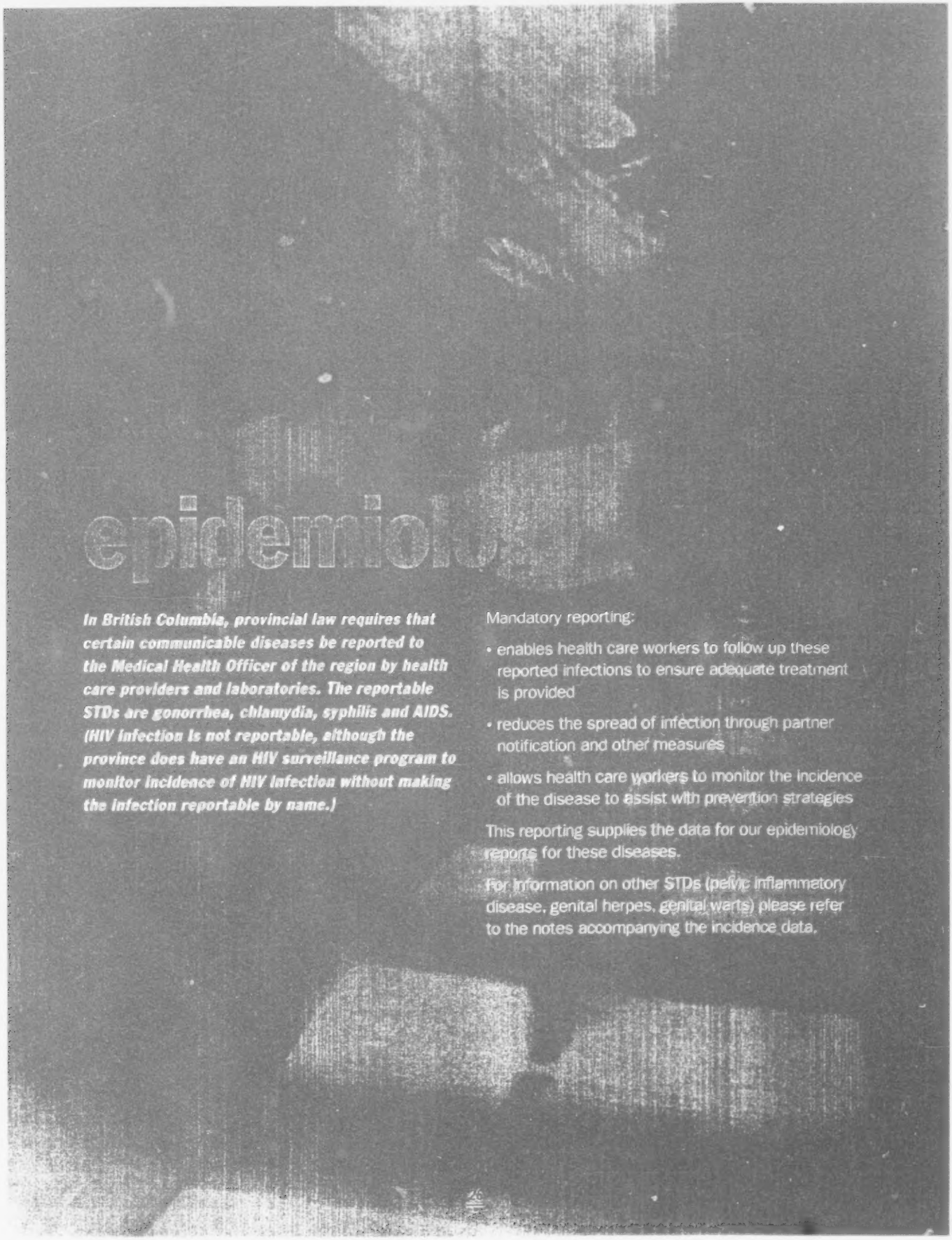
the way forward

The entire staff at STD/AIDS Control is justifiably proud of our achievements over the past months – the services provided, the care given, the skills taught, the knowledge shared.

We will continue to constantly re-evaluate and focus our efforts to meet the changing conditions of our society, and of our clients. Measures that have proven effective will be maintained and new strategies and resources to meet emerging needs will be developed.

Concentrating on improving services to those most at-risk, including ethnic minorities, poor women and Aboriginals will be a priority. We will focus our efforts on key issues such as reproductive health. We'll work to develop better tools such as HIV rapid point-of-care diagnostics and support innovative applied public health research.

We will continue to pursue our mandate of STD prevention and control, in British Columbia and beyond.



epidemiology

In British Columbia, provincial law requires that certain communicable diseases be reported to the Medical Health Officer of the region by health care providers and laboratories. The reportable STDs are gonorrhea, chlamydia, syphilis and AIDS. (HIV infection is not reportable, although the province does have an HIV surveillance program to monitor incidence of HIV infection without making the infection reportable by name.)

Mandatory reporting:

- enables health care workers to follow up these reported infections to ensure adequate treatment is provided
- reduces the spread of infection through partner notification and other measures
- allows health care workers to monitor the incidence of the disease to assist with prevention strategies

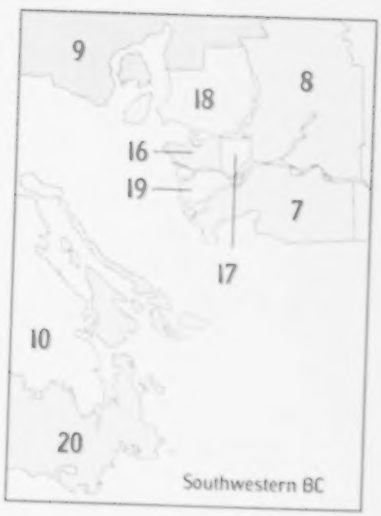
This reporting supplies the data for our epidemiology reports for these diseases.

For information on other STDs (pelvic inflammatory disease, genital herpes, genital warts) please refer to the notes accompanying the incidence data.

BC by Health Authority Reference Map

Health Authority

1 East Kootenay
2 West Kootenay - Boundary
3 North Okanagan
4 South Okanagan - Similkameen
5 Thompson
6 Fraser Valley
7 South Fraser Valley
8 Simon Fraser
9 Coast Garibaldi
10 Central Vancouver Island
11 Upper Island/Central Coast
12 Cariboo
13 North West
14 Peace Liard
15 Northern Interior
16 Vancouver
17 Burnaby
18 North Shore
19 Richmond
20 Capital



chlamydia

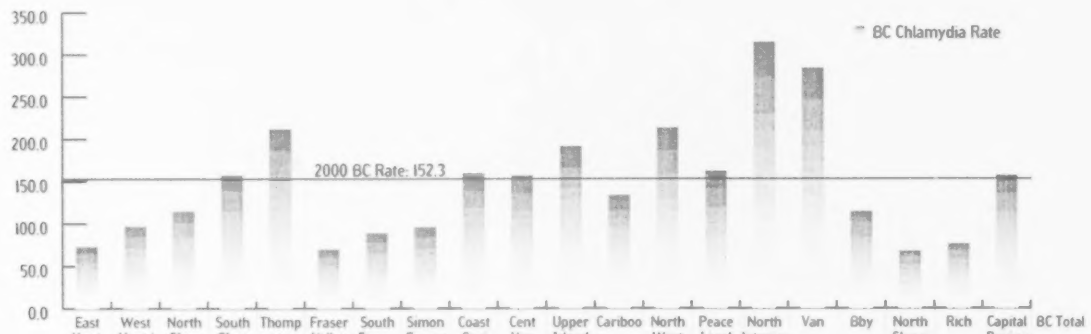
2.1 BC Chlamydia cases and rates (per 100,000)

From 1999 to 2000 the overall provincial number increased by 838 cases (15.6%), or an increase in rate from 132.4 per 100,000 population to 152.3 per 100,000 population.

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC Cases	7,294	6,434	5,321	5,366	4,660	4,116	4,116	4,769	5,355	6,193
BC Rate	216.2	185.4	149.0	145.7	123.1	106.0	104.0	118.9	132.4	152.3
Can. Rate	180.2	163.4	153.4	142.0	127.4	116.0	113.8	129.9	121.0	141.8
Population	3,373,399	3,470,307	3,571,525	3,681,750	3,784,008	3,882,043	3,959,338	4,009,922	4,045,661	4,067,179

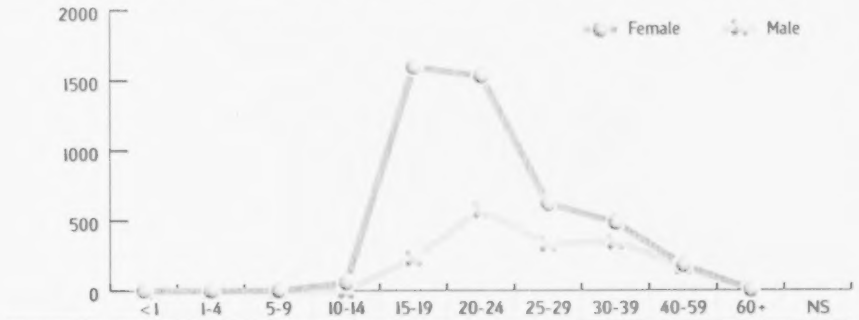
2.2 Chlamydia disease reports by Health Authorities (per 100,000)

Compared to 1999, chlamydia rates doubled in East Kootenay, North Okanagan, Coast Garibaldi and Northern Interior health regions. Okanagan Similkameen had a 50% increase. Most other regions had modest increases and three regions had minor decreases. The increased rates may be due to increased public awareness and more testing.



	East Koot.	West Koot/ Boun	North Okan	South Okan Simlk	Thomp son	Fraser Valley	South Fraser Valley	Simon Fraser	Coast Gari baldi	Cent Van Island	Upper Island	Cariboo	North West	Peace Liard	North Interior	Van	Bby	North Shore	Rich	Capital Region	BC Total
Cases	61	81	138	369	293	172	517	315	129	387	236	104	197	108	423	1639	222	124	128	529	6193
Rate	73.9	97.9	115.7	158.3	212.9	70.7	89.8	96.9	160.4	157.8	192.2	134.7	214.2	163.0	315.5	284.7	115.4	68.7	77.1	158.0	152.3
Population	82552	82758	119250	233133	137639	243175	575919	325224	80448	245279	122809	77188	91959	66254	134081	575744	192370	180432	166118	334847	4,067,179

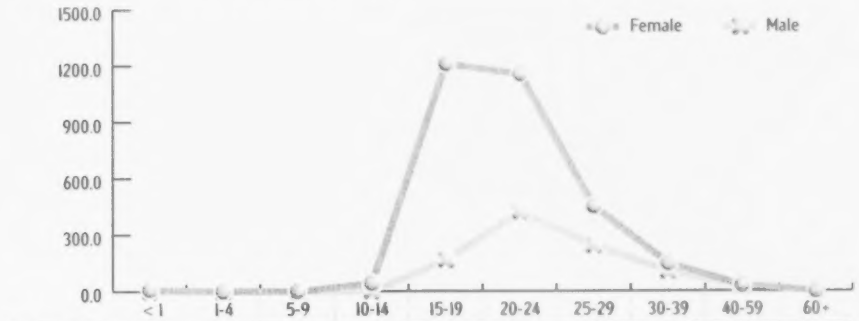
2.3 Chlamydia cases by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	NS
Female	2	-	1	55	1594	1529	620	486	178	3	33
Male	-	-	-	1	231	575	334	349	167	9	24
Unkown	-	-	-	-	-	1	-	-	-	-	1
Total	2	-	1	56	1825	2105	954	835	345	12	58

Female case numbers are more than double the number of male cases. This persistent gender discrepancy may be due to lower rates of chlamydia screening in men than in women. Chlamydia rates have increased in both males and females from 1999.

2.4 Chlamydia rates by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+
Female	9.9	-	0.8	43.3	1210.9	1157.5	451.7	148.0	30.6	0.8
Male	-	-	-	0.7	166.2	422.9	242.2	105.1	28.8	2.8

gonorrhea

2.5 BC Gonorrhea cases and rates (per 100,000)

From 1999 to 2000 the overall provincial number decreased by 154 cases (17.5%) or a decrease in rate from 21.7 per 100,000 to 17.8 per 100,000 population.

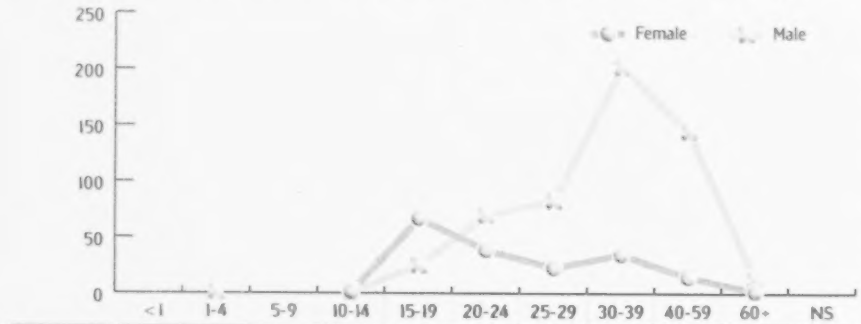
	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC Cases	1,928	1,332	1,414	1,224	777	550	489	492	488	458	541	878	724
BC Rate	61.9	41.6	43.0	36.3	22.4	15.4	13.3	13.0	12.6	11.6	13.5	21.7	17.8
Can. Rate	75.0	70.0	49.9	44.4	32.6	23.8	21.2	19.5	16.9	15.1	16.7	18.8	14.8
Population	3,115,665	3,198,547	3,291,379	3,373,399	3,470,307	3,571,525	3,681,750	3,784,008	3,882,043	3,959,338	4,009,922	4,045,661	4,067,179

2.6 Gonorrhea disease reports by Health Authorities (per 100,000)

Most regions had decreases in numbers of cases. In those having increases the numbers are small. Vancouver and Burnaby are the only two health regions exceeding the provincial average. Levels of resistant strains of gonorrhea remain fairly constant in BC.

	East Koot.	West Koot/ Boun	North Okan	South Okan Similk	Thompson	Fraser Valley	South Fraser Valley	Simon Fraser	Coast Garibaldi	Cent Van Island	Upper Island	Cariboo	North West	Peace Liard	North Interior	Van	Bby	North Shore	Rich	Capital Region	BC Total
Cases	-	1	5	19	12	11	56	46	10	14	11	1	12	2	2	428	37	26	6	16	724
Rate	-	1.2	4.2	8.1	8.7	4.5	9.7	14.1	12.4	5.7	9.0	1.3	13.0	3.0	1.5	74.3	19.2	14.4	3.6	4.8	17.8
Population	82,552	82,758	119,250	233,133	137,639	243,175	575,919	325,224	80,448	245,279	122,809	77,188	91,959	66,254	134,081	575,744	192,370	180,432	166,118	334,847	4,067,179

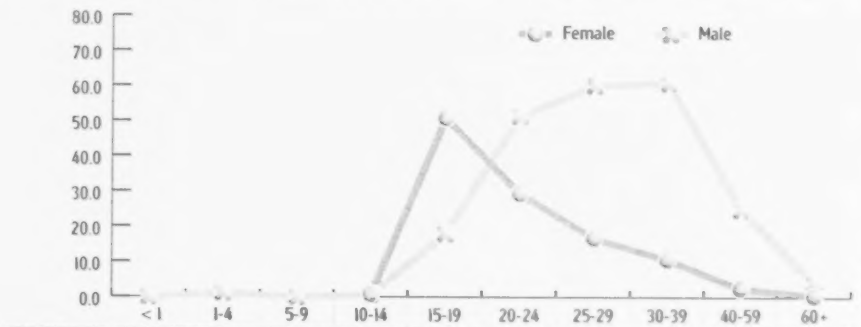
2.7 Gonorrhea cases by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	NS
Female	–	–	–	1	67	39	23	35	15	2	1
Male	–	1	–	1	25	70	83	202	145	13	–
Unkown	–	–	–	–	1	–	–	–	–	–	–
Total	–	1	–	2	93	109	106	237	160	15	1

Males account for 75% of total cases. 40.8% of all cases are found in heterosexual men and 24.8% are found in men having sex with men (MSM). Gonococcal infection rates have decreased from 1999 in men and women 20 –29 years of age. The relatively low rate of gonococcal infection found in women suggests that there may be significantly less testing and/or lower rates of gonococcal isolation from cervical specimens.

2.8 Gonorrhea rates by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+
Female	–	–	–	0.8	50.9	29.5	16.8	10.7	2.6	0.5
Male	–	1.1	–	0.7	18.0	51.5	60.2	60.9	25.0	4.1

syphilis

2.9 BC Syphilis cases and rates (per 100,000)

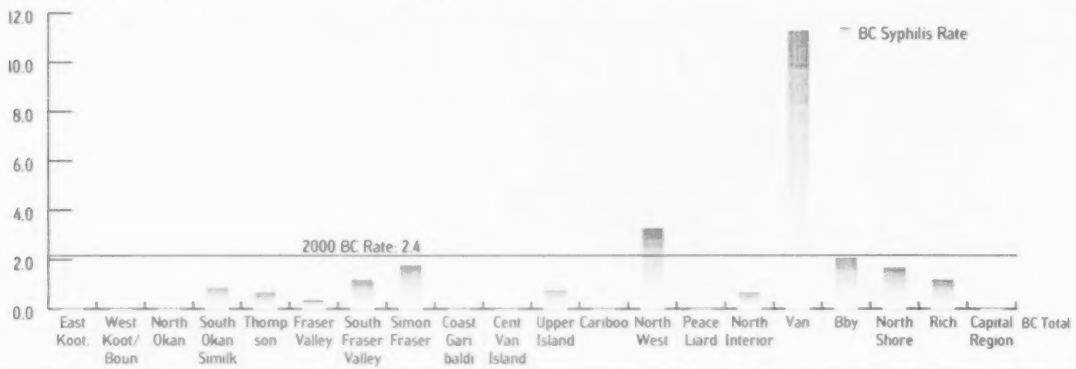
From 1999 to 2000 the overall provincial number decreased by 31 cases or 24%; a decrease in rate from 3.1 per 100,000 population to 2.4 per 100,000 population.

The mass treatment initiative implemented in the Lower Mainland regions in early 2000 is the most likely reason numbers decreased. A small outbreak was documented in the Northwest region during 2000.

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC Cases	53	42	42	50	30	16	17	18	18	50	112	127	96
BC Rate	1.7	1.3	1.3	1.5	0.9	0.4	0.5	0.5	0.5	1.3	2.8	3.1	2.4
Can. Rate	4.8	4.6	4.1	3.8	2.8	2.4	1.7	1.5	2.3	2.0	1.8	1.2	1.5
Population	3,115,665	3,198,547	3,291,379	3,373,399	3,470,307	3,571,525	3,681,750	3,784,008	3,882,043	3,959,338	4,009,922	4,045,661	4,067,179

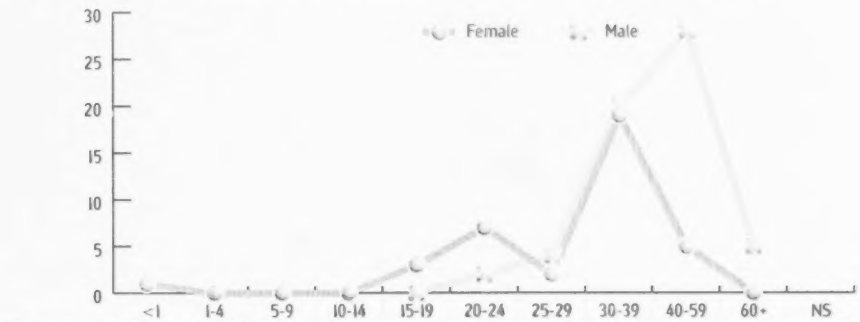
3.0 Syphilis disease reports by Health Authorities (per 100,000)

Vancouver and the Northwest region are the only two regions exceeding the provincial average rate per 100,000 population. The number of cases decreased in Vancouver/Richmond from 96 in 1999 to 67 in 2000. This represents a 30% decrease in cases for the Vancouver/Richmond region. One Lower Mainland region (South Fraser) also had a 40% decrease in cases, Simon Fraser (including Burnaby) remained constant at 10 cases and the North Shore increased from 2 to 3 cases.



	East Koot.	West Koot/ Boun	North Okan	South Okan Similk	Thomp son	Fraser Valley	South Fraser Valley	Simon Fraser	Coast Garibaldi	Cent Van Island	Upper Island	Cariboo	North West	Peace Liard	North Interior	Van	Bby	North Shore	Rich	Capital Region	BC Total
Cases	-	-	-	2	1	1	7	6	-	-	1	-	3	-	1	65	4	3	2	-	96
Rate	-	-	-	0.9	0.7	0.4	1.2	1.8	0.0	0.0	0.8	0.0	3.3	0.0	0.7	11.3	2.1	1.7	1.2	0.0	2.4
Population	82,552	82,758	119,250	233,133	137,639	243,175	575,919	325,224	80,448	245,279	122,809	77,188	91,959	66,254	134,081	575,744	192,370	180,432	166,118	334,847	4,067,179

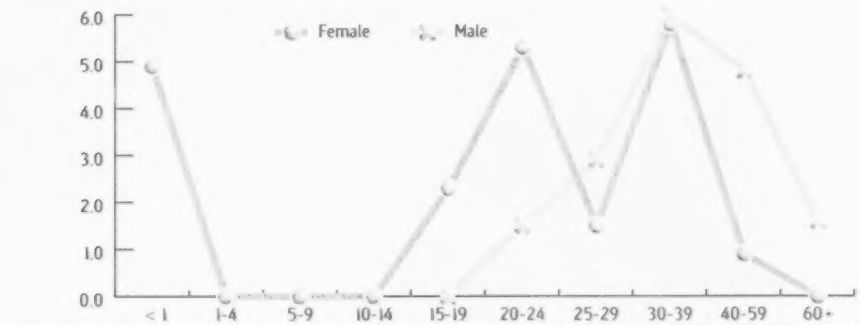
3.1 Syphilis cases by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	NS
Female	1	–	–	–	3	7	2	19	5	–	–
Male	–	–	–	–	–	2	4	20	28	5	–
Total	1	–	–	–	3	9	6	39	33	5	–

Males account for 61.5% of the total syphilis cases with 81% (50% of all cases) being in males 30-59 years old. 51% of female cases were 30-39 years old.

3.2 Syphilis rates by gender and age (per 100,000)



	< 1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+
Female	4.9	–	–	–	2.3	5.3	1.5	5.8	0.9	–
Male	–	–	–	–	–	1.5	2.9	6.0	4.8	1.6

HIV

3.3 BC New positive HIV test rates (per 100,000)

From 1999 to 2000 the overall provincial number of new positive HIV tests decreased from 427 to 413 (3.3%); a decrease in rate from 10.6 per 100,000 population to 10.2 per 100,000 population.

Injection drug users and heterosexuals showed a decline in numbers of new infections while men having sex with men presented an increase in numbers of new infections. The two categories that showed declines in positive tests also had declines in numbers of persons testing. MSM testing numbers were consistent.

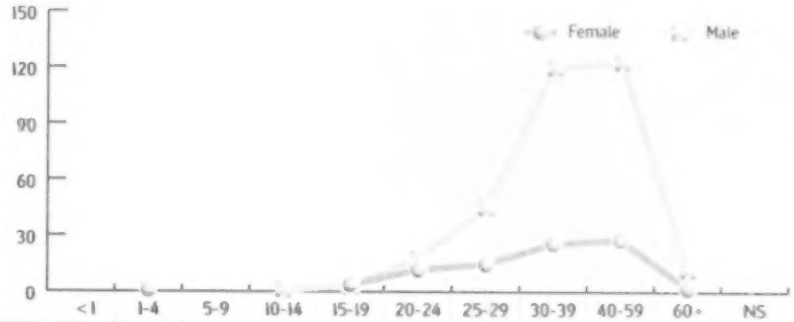
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC Cases	645	704	788	706	840	690	715	561	482	427	413
BC Rate	19.6	20.9	22.7	19.8	22.8	18.2	18.4	14.2	12.0	10.6	10.2
Population	3,291,379	3,373,399	3,470,307	3,571,525	3,681,750	3,784,008	3,882,043	3,959,338	4,009,922	4,045,661	4,067,179

3.4 New positive HIV test reports by Health Authority (per 100,000)

The only health region exceeding the provincial average was Vancouver but Vancouver also had a significant rate decrease from 53.96 to 42.03. Numbers of tests done in Vancouver have remained fairly constant over the past 5 years.

	East Koot.	West Koot/ Boun	North Okan	South Okan Similk	Thompson	Fraser Valley	South Fraser Valley	Simon Fraser	Coast Garibaldi	Cent Van Island	Upper Island	Cariboo	North West	Peace Liard	North Interior	Van	Bby	North Shore	Rich	Capital Region	BC Total
Cases	1	1	5	13	6	22	19	30	2	13	3	2	1	2	3	242	15	6	–	27	413
Rate	1.2	1.2	4.2	5.6	4.4	9.0	3.3	9.2	2.5	5.3	2.4	2.6	1.1	3.3	2.2	42.0	7.8	3.3	–	8.1	10.2
Population	82,552	82,758	119,250	233,133	137,639	243,175	575,919	325,224	80,448	245,279	122,809	77,188	91,959	66,254	134,081	575,744	192,370	180,432	166,118	334,847	4,067,179

3.5 New positive HIV test cases by gender and age (per 100,000)

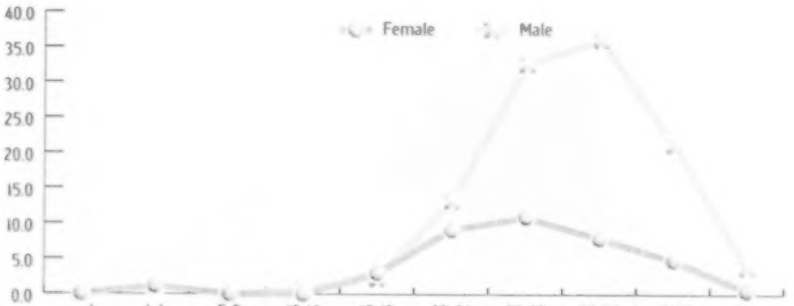


	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	NS
Female	–	1	–	–	4	12	15	26	28	2	1
Male	–	1	–	1	3	18	45	120	123	12	1
Total	–	2	–	1	7	30	60	146	151	14	2

Males made up 78.5% of new positive HIV tests in British Columbia in 2000 with most of these in males aged 30 – 59 years. 60.7% of female cases were also in the 30 –59 year age group.

The ethnic group showing the greatest increase was Asians (from 13 to 26 new cases with increases in both genders). Hispanics and Blacks also had increases in males from 12 to 20 and 19 to 26 respectively. First Nations and South Asians had decreases from 73 to 55 and 10 to 6 respectively. Levels of testing in these groups remained fairly constant.

3.6 New positive HIV test rates by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+
Female	0.0	1.1	0.0	0.0	3.0	9.1	10.9	7.9	4.8	0.5
Male	0.0	1.1	0.0	0.7	2.2	13.2	32.6	36.1	21.2	3.8

The rate per 100,000 population for females decreased from 5.46 in 1999 to 4.35 in 2000, while the rate for males increased from 15.66 in 1999 to 16.05 in 2000.

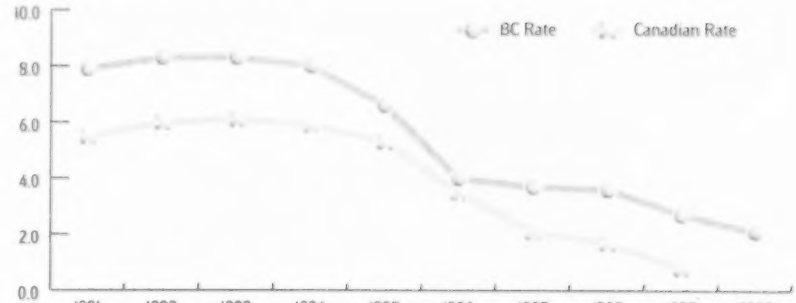
AIDS

3.7 BC AIDS cases and rates (per 100,000)

From 1999 to 2000 the overall provincial number of reported AIDS cases decreased from 111 to 85 continuing the downward trend that began in 1993. The decrease in rate was 2.7 per 100,000 population to 2.1 per 100,000 population.

Reported cases in injection drug users and heterosexuals showed modest declines while numbers of MSM remained constant.

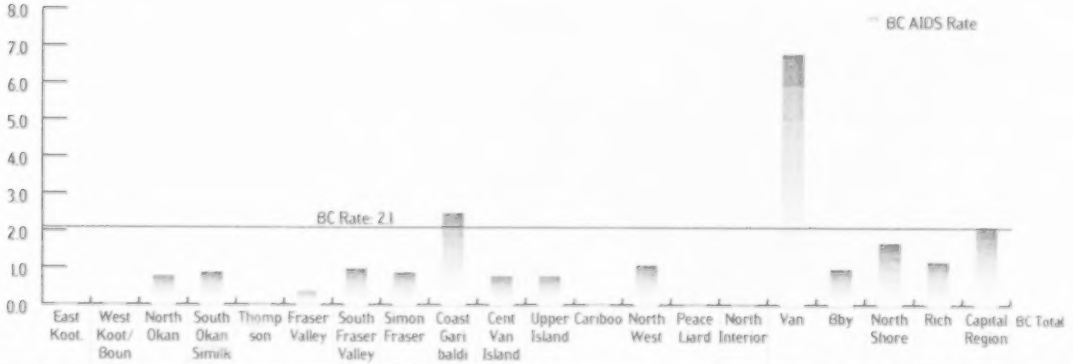
Although the B.C. rate is higher than the Canadian rate, the trend is similar.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BC Cases	265	287	296	294	251	156	146	144	111	85
BC Rate	7.9	8.3	8.3	8.0	6.6	4.0	3.7	3.6	2.7	2.1
Can. Rate	5.5	6.0	6.1	5.9	5.3	3.5	2.1	1.7	0.8	-
Population	3,373,399	3,470,307	3,571,525	3,681,750	3,784,008	3,882,043	3,959,338	4,009,922	4,045,661	4,067,179

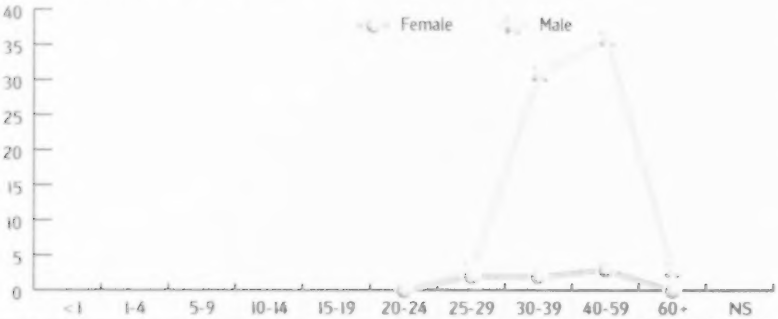
3.8 AIDS cases by Health Authorities (per 100,000)

Health regions exceeding the provincial average rate per 100,000 population are Vancouver, Coast Garibaldi and Capitol Health Region. Vancouver, although having the largest number of cases in the province, has continued to see a decline in numbers of cases from 62 in 1999 to 41 in 2000.



	East Koot.	West Koot/ Boun	North Okan	South Okan Similk	Thomp son	Fraser Valley	South Fraser Valley	Simon Fraser	Coast Gari baldi	Cent Van Island	Upper Island	Cariboo	North West	Peace Liard	North Interior	Van	Eby	North Shore	Rich	Capital Region	BC Total
Cases	-	-	1	2	-	1	6	3	2	2	1	-	1	-	-	39	2	3	2	7	85
Rate	-	-	0.8	0.9	-	0.4	1.0	0.9	2.5	0.8	0.8	-	1.1	-	-	6.8	1.0	1.7	1.2	2.1	2.1
Population	82,552	82,758	119,250	233,133	137,639	243,175	575,919	325,224	80,448	245,279	122,809	77,188	91,959	66,254	134,081	575,744	192,370	180,432	166,118	334,847	4,067,179

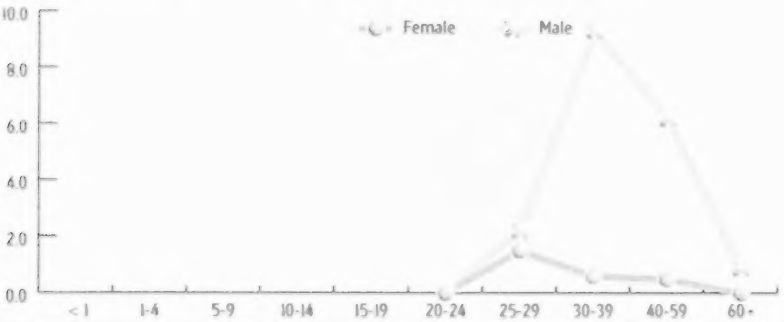
3.9 AIDS cases by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	NS
Female	-	-	-	-	-	-	2	2	3	-	-
Male	-	-	-	-	-	-	3	31	36	3	3
Unkown	-	-	-	-	-	-	-	2	-	-	-
Total	-	-	-	-	-	-	5	35	39	3	3

Males made up 89% of new AIDS cases in British Columbia in 2000 with 88% of these in males aged 30 – 59 years. Both genders continue to have small rate declines.

4.0 AIDS rates by gender and age (per 100,000)



	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+
Female	-	-	-	-	-	-	1.5	0.6	0.5	-
Male	-	-	-	-	-	-	2.2	9.3	6.2	0.9

pelvic inflammatory disease

4.1 BC Pelvic Inflammatory Disease cases and rates (per 100,000)

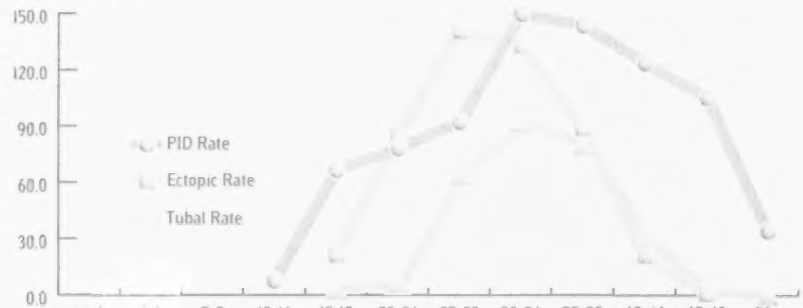
Rates of Pelvic Inflammatory Disease (PID) are measured based on hospital admissions for this diagnosis. Due to changes in acute care bed availability and because many cases of PID can be managed as an outpatient, hospital cases significantly underestimate total cases.

The most recent data available is from 1999. Total cases have declined over the last decade by 60% to 1024 cases reported in 1999. There was a modest increase from 104.59 per 100,000 in 1998 to 113.3 per 100,000 in 1999 – too small to be called a trend.

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Female Cases	3322	3079	2888	2416	2438	2204	1984	1742	1557	1361	1235	1142	948	1024
Female Rate	462.1	424.3	391.6	320.2	314.6	278.7	245.7	210.8	183.6	156.8	138.5	126.2	104.5	113.3

Tubal infertility and ectopic pregnancy rates have also declined over the past decade suggesting a true decrease in pelvic inflammatory disease which is the primary cause of these complications. Despite these improvements, PID rates remain relatively high in some geographic areas including the Northern Interior, West Kootenay-Boundary, Peace Liard and other areas of central BC (see chart).

4.2 BC Pelvic Inflammatory Disease cases and rates (per 100,000)



	< 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	Total
PID Rate	-	-	-	7.9	66.6	78.3	92.0	149.6	143.5	123.2	105.0	34.1	68.8
Ectopic Rate	-	-	-	-	21.4	84.4	140.5	132.7	88.7	20.9	0.6	-	36.2
Tubal Rate	-	-	-	-	3.0	6.1	63.5	91.0	79.7	29.0	1.2	0.3	21.5
PID Cases	-	-	-	10	87	102	129	230	254	212	163	206	1,393
Ectopic Cases	-	-	-	-	28	110	197	204	157	36	1	-	733
Tubal Cases	-	-	-	-	4	8	89	140	141	50	2	2	436

genital herpes

A recently published study* showed that the prevalence rate of antibodies to HSV-2 in women in BC, based on anonymous seroprevalance data, is 17.3% with the highest rate in 40 – 44 year olds.

Local Vancouver STD clinic data reveals persistent high rates of clinical disease.

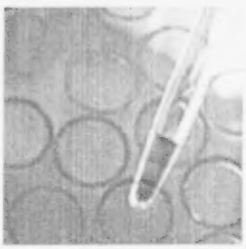
The burden of herpes in the province remains mostly unrecognized as type specific serology is currently unavailable.

*Antenatal Seroprevalence of Herpes Simplex Virus Type 2 (HSV-2_ in Canadian Women. Patrick, D.M., Dawar, M., Cook, D.A., Krajden, M., Ng, H.C., Rekart, M.L., *Antenatal Seroprevalence of Herpes Simplex Virus Type 2 (HSV-2) in Canadian Women.* Sexually Transmitted Diseases. 2001; 28(7).

genital warts

Genital warts are clinically diagnosed and human papilloma virus detection is not currently available as routine care in British Columbia. Given this, an assessment of the burden of this common sexually transmitted disease is difficult to quantify.

At the Vancouver STD clinic, 4% of visits for STD assessment results in a diagnosis of genital warts. These are most commonly treated with liquid nitrogen.



STD/AIDS Control staff

Staff List

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Catherine Astin, Outreach Nurse
Kelly Bains, Clinic Clerk
Jacqueline Barnett, Nursing Education Administrator
Lucy Barney, Program Manager, BCAAAP
Caroline Brunt, Outreach Nurse
Bubli Chakraborty, Outreach Nurse
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Bill Coleman, Clinic Psychologist
Kathryn Collister, Outreach Nurse
Carlene Coplin, Clinic Clerk
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Byron Cruz, Outreach Health Care Worker
Monika Csobot, Outreach Nurse
Anne Doherty, Clinic Nurse
Glenn Doupe, Clinic Nurse
Lisa Elliot, Clinic Nurse
Doreen Fleury, Clinic Nurse
Ellen Fraser, Education Assistant
Fiona Gold, Outreach Nurse
Gaye Goldstein, Clinic Nurse
Paul Harris, Outreach Nurse
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Linda Knowles, Clinic Nursing Administrator
Witty Lau, Clinic Clerk
Patricia Lauener, Clinic Nurse
Ellen Leung, Resource Centre Clerk
Laurene Lewis, Clinic Nurse
Anne Lidstone, Clinic Nurse
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Cheryl Prescott, Clinic Nurse
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Betsy Reilly, Clinic Clerk
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Karen Stretch, Outreach Clerk
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Lynn Wittenberg, Clinic Nurse
Kathy Wrath, Outreach Nurse
Grace Young, Clinic Nurse
Norah Young, Office Manager
Dr. Margery Zapf-Gilje, Sessional Physician

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